Lifeways Community Care Limited

Lifeways Community Care (Warwickshire & Coventry)

Inspection report

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Date of inspection visit:
25 July 2022
26 July 2022
27 July 2022

Date of publication:
23 January 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Lifeways Community Care (Warwickshire & Coventry) provides personal care to people in their own homes within supported living and domiciliary care settings. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection there were 34 people receiving personal care, some of whom may have a learning disability, autism, mental health needs or physical disability.

People's experience of using this service and what we found
The service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support:
The provider had not fully protected people from the risk of abuse and improper treatment. Individual risks were not always assessed and managed to keep people safe. Risk assessments were inconsistent and did not always detail the relevant information staff would need to meet people's assessed care and health needs. Incidents and accidents involving people were not consistently reported, recorded and investigated.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care: The provider did not protect people from poor care and abuse. The provider failed to ensure service users were always treated with respect and dignity whilst receiving care and treatment. There were not always enough appropriately skilled staff to meet people's needs and keep them safe.

Right Culture: The provider did not always place people's wishes, needs and rights at the heart of everything they did. The provider had failed to implement effective systems to assess, monitor and improve the service. We found the language used in some people's care plans to be disrespectful and undignified.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 29 April 2019).

Why we inspected
The inspection was prompted in part due to concerns received about a closed culture, allegations of abuse and neglect and poor managerial oversight. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken some steps to mitigate the risk since our inspection. This includes liaison with relevant partner services to keep people safe and developing a service improvement plan.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, dignity and respect, need for consent, safe care, safeguarding, meeting people's nutritional and hydration needs, governance and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Lifeways Community Care (Warwickshire & Coventry)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in four 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 July 2022 and ended on 2 August 2022. We visited the providers offices on 25 July 2022 and visited one of the providers services on 26 July and 27 July 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with six people who used the service and 10 relatives and friends of people who used the service. We also spoke with five members of staff including the registered manager, regional operations director, service manager and care staff. We reviewed a range of records. This included five people's care records and five people's medication records. We looked at two staff files in relation to recruitment and staff competencies. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider had not fully protected people from the risk of abuse and improper treatment. People were not kept safe from avoidable harm because staff did not understand how to protect them from abuse. The service did not work well with other agencies to do so.
- During the inspection we were made aware of a serious allegation of abuse. The provider had not recognised this as abuse at the time of the incident, investigated or taken further action to safeguard the person, including notifying the relevant external agencies. The registered manager took action when we raised our concerns with them.
- People told us they were not listened to when raising safeguarding concerns. One person told us the provider had not taken any action when they reported a safeguarding concern. We saw evidence corroborating these statements.
- Not all staff had received safeguarding training to ensure they knew how to identify and report abuse concerns. Some staff we spoke with lacked understanding of the different forms of abuse and their associated responsibilities. Since the inspection, the provider has ensured staff undertook safeguarding training.
- Incidents and accidents involving people were not consistently reported, recorded and investigated to promote learning and minimise the risk of reoccurrence. Although the provider had a system in place to report incidents, this had only been in use for two months at the time of the inspection. We could find no records relating to incidents prior to this date.
- We saw entries in one person's care records indicated they had been involved in 42 instances of choking. The provider had failed to ensure these events were reported and recorded. This meant there was a missed opportunity to identify patterns or trends to reduce the risk of reoccurrence.
- We were made aware of a serious incident regarding a person's safety. The person told us the incident had been reported to the service manager; staff we spoke with were aware of the incident. There were no records relating to the incident and no investigation had been completed. This meant there was a missed opportunity to keep people safe and learn from the incident.

The provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- We were not assured the provider was keeping people safe through assessing and managing risks to their health and safety.
- Risk assessments had not always been completed in relation to known risks to people or plans developed

for managing these risks. For example, one person required the use of a particular medical device. We found staff had not been provided with clear guidance on how to manage the risks associated with its use.
●Where people had known health conditions, care plans and risk assessment were not always in place. For example, one person had been diagnosed with a long-term physical health condition. No care plan was in place to guide staff on how to help the person manage the condition. In addition, some staff told us they had not read any care plans for a year. This increased the risk of people receiving unsafe or inconsistent care.
● The provider had failed to carry out assessments of people's needs. For example, we saw one person was prescribed medicines to treat serious mental illness. There was no assessment or care plan in place referring to the condition for staff to follow. This increased the risk of people's health conditions being untreated or worsening.
● People's risk assessments had not been updated or reviewed following incidents. For example, one person had been involved in a significant number of choking incidents over a prolonged period of time. No risk assessment or care plan was updated following the incidents to mitigate the risk of reoccurrence.
● We were not assured staff were using and disposing of personal protective equipment (PPE) correctly. We saw staff incorrectly wearing facemasks and PPE disposed of in general waste bins.
● One person's care records indicated they had recently had an occupational health assessment. We found no record detailing the assessment or the recommendations. Another person was a risk of choking, we saw no evidence of any involvement from the SALT team. This meant people were at risk of worsening health conditions.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had failed to ensure there were sufficient numbers of staff on duty to meet people's needs. The providers own audit had identified staffing levels were 30% below the required level. The provider was utilising agency staff to cover the shortfall.
● One person told us there was often not enough staff to meet their needs. This meant they would have to complete tasks without the required support placing them at risk of injury. Another person was a wheelchair user and required support with washing. They told us they would often have to bathe themselves due to staff shortages. This increased the risk of harm. Some people's relatives told us they were concerned about staffing levels within the service. One person's relative told us the service was short-staffed.
● Some people's relatives told us they were concerned regarding the use of agency staff. One person's relative told us, "To make things better they need to use less agency staff." Another person's relative told us "The agency staff they use can't cook. They don't encourage [Person's relative] to eat; they've lost 10kg." The lack of effective care plans and risk assessments to guide agency staff increased the risk of people receiving unsafe care.
● The registered manager made use of a tool designed to identify the correct number of staff required. We looked at this tool and found it to be incorrectly used and therefore ineffective. This meant the provider could not be sure how many staff were required each day to care for people.

The provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● The provider had not always provided staff with written guidance on when to offer people medicines which were to be administered on an 'as and when required' basis (PRN medicine). This meant there was an increased risk PRN medication might be used inappropriately. This was immediately rectified by the registered manager.

● Although audits of medicines were carried out, these were undertaken by care staff and not the service manager. This contradicted the provider's own medicine policy. This increased the risk of errors due to an untrained or inexperienced member of staff completing the audits.

● People and their relatives we spoke with told us they were supported with their medicines and expressed no concerns.

Inadequate

Is the service effective?

Our findings

Is the service effective?

Our findings - Is the service effective? = Inadequate

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices had not always been fully assessed. Staff failed to complete a comprehensive assessment of each person's physical and mental health either on admission or soon after. We found no evidence of any recorded assessment of one person's needs and preferences. This meant people were at risk of receiving care that was inappropriate to their needs.
- Where assessments had been carried out, they did not always take into account all of people's needs. For example, one person's assessment whose capacity was in doubt, did not consider their ability to make particular decisions. Another person's assessments contained contradictory information regarding a potential diagnosis of diabetes.
- When people's needs and choices changed, the provider failed to keep assessments under review. For example, one person's healthcare needs were known to have changed. The provider had failed to reassess the person's new healthcare needs.
- People and their relatives were not involved in assessments of their needs. People we spoke with told us they had not been involved in developing their care plans.

Staff support: induction, training, skills and experience

- People were not supported by staff who had received relevant and good quality training in evidence-based practice. This included training in the wide range of strengths and impairments people with a learning disability and or autistic people may have, mental health needs, communication tools, positive behaviour support, trauma-informed care, human rights and all restrictive interventions.
- Although the provider had a system in place to monitor staff training needs, they had failed to ensure training was kept up to date. We saw significant gaps in staff training records including safeguarding, basic first aid and manual handling.
- The provider had failed to provide specific training to staff which was reflective of people's specific health and care needs. For example, staff were supporting people diagnosed with acquired brain injuries, mental health diagnoses, diabetes, autistic people and people with a learning disability, amongst others. Some staff we spoke with lacked understanding of how people's health conditions affected people. This meant people were at risk of being cared for by staff who did not have the required skills to meet their needs.

● The provider had failed to ensure staff received any formal supervision or support. The provider told us they had not undertaken any supervisions. Staff told us they had not received any supervisions. This meant staff did not that the opportunity to discuss their development or training needs.

The provider had failed to ensure staff received appropriate support, training, supervision and appraisal. This placed people at risk of harm. This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

●We were not assured people's nutrition and hydration needs were being met. People with complex needs did not receive support to eat and drink in a way that met their personal preferences as far as possible. We found where assessments had been completed of people's nutritional and hydration needs, they did not always clearly identify specialist nutritional advice received or explain how to support them to eat and drink safely. Due to the lack of written guidance for staff to follow and the use of agency staff, this placed people at risk of harm.

● One person's care records indicated they had been referred to the speech and language therapy (SALT) team and an assessment had been carried out. We found no other reference to, or evidence of SALT involvement in their care records, including the details of their recommendations.

● Care records included contradictory guidance regarding people's needs. For example, one person's records described a person needing meals in 'bite sized' pieces. Another document stated food should be cut up no larger than a 5p piece. In addition, there was no reference to the International Dysphagia Diet Standardisation Initiative (IDDSI) Framework or foods to avoid. The IDDSI Framework provides a common terminology to describe food textures and drink thickness. This meant we could not be assured people were receiving support to eat and drink in line their assessed needs and any specialist nutritional advice received. This placed people at increased risk of harm.

● One person was diabetic. The provider had failed to provide staff with written guidance on how to prepare meals including dietary guidelines for the management of their diabetes.

● Where people required monitoring of their nutrition and hydration intake, the provider had failed to ensure this was completed. For example, one person was known to be a risk of choking and their assessment instructed staff to record food and fluid intake. The provider told us the records had not been kept.

The provider's failure to meet people's nutritional and hydration needs was a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA

● The provider was not working in line with the principles of the MCA. They were unable to evidence that people's rights under the MCA were being protected. Assessment and care planning processes did not always consider people's capacity to consent to care and treatment.

● One person was being supported on a one to one basis. We found no evidence of how the decision to supervise people in this way had been made or any considerations of this being in their best interests.

● People were not consulted and included in the decisions about the use of surveillance. One person had a remote monitoring device placed outside their room each night so the staff could monitor their movements. We found no supporting documentation to evidence the reasons for this decision and that it was in the persons best interests. Furthermore, there was no evidence of involvement from the person regarding their consent to have the monitor in place.

● Where people's capacity was in doubt, the provider had failed to ensure decision specific capacity assessments were carried out. One person's assessment stated an acquired brain injury had impacted their ability to make complex decisions. There was no further reference to the person's capacity within their care records including their ability to make decisions relating to their care and treatment. This meant the person was at risk of receiving care they had not consented to.

The provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● We were not assured the provider had always liaised effectively with other agencies, teams and professionals to ensure people's health needs were met.

● Where people had seen by external health care professionals there was no record of the advice or guidance given by the professional for staff to follow. This meant people were at risk of receiving inappropriate care which did not meet their needs.

● Some people's relatives told us they had not been kept up to date about their relative's care. For example, one person's relative told us "I'm not invited to any reviews."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- The provider had failed to ensure people were treated with dignity and respect at all times. People told us they did not feel listened to by the provider. As a result, people did not feel safe in their own home and were left in an undignified situation.
- One person had been involved in a serious incident. The person told us they had not been listened to when raising concerns with the service manager. They told us they were "Fobbed off" and accused of "Creating a witch hunt." This had caused the person to feel scared and unsafe in their own home. We found the provider's response to the allegations uncaring, leaving the person in an undignified situation.
- Another person told us they had been purchased a new bed by the provider without consenting to it or being informed. The bed was inappropriate for a person with their needs leading to the person becoming unwilling to use the bed. The person resorted to sleeping in an armchair or another person's room. The provider failed to act in good time to remove the bed which meant the person was left in a preventable, undignified situation.
- We found the language used in some people's care plans to be disrespectful and undignified. For example, one person's care plan stated, 'I like to get my own way, I am quick to see the wrong in people.' A further comment was, 'Can become slightly rude and uncooperative and can be described as childish.' Another statement read, 'What support do I need; seeing others view and accepting I am not always right.' This choice of language was uncaring.

The provider failed to ensure service users were always treated with respect and dignity whilst receiving care and treatment This was a breach of Regulation 10 (Dignity and Respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Supporting people to express their views and be involved in making decisions about their care

- The provider had failed to ensure people and their relatives were involved in making decisions about their care. People and their relatives we spoke with told us they had not been involved in assessments or reviews of their care. This meant people did not have the opportunity to contribute towards decisions made regarding their care and could be at risk of receiving inappropriate care.
- The provider had made information available to people and their families about advocacy services that can provide independent support and advice.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans did not always provide staff with clear guidance on how to meet their individual needs. For example, one person had physical disability. There was no information made available for staff detailing the nature or impact of the conditions. This meant people were at risk of receiving care from staff who did not understand their needs.
- Another person's assessment identified a number of significant health concerns which impacted on the person. Care plans had not been developed for these conditions. This meant people were at risk of worsening healthcare conditions. Some staff we spoke with lacked knowledge of peoples health care conditions or how to support people with them.
- Staff did not always discuss ways of ensuring people's goals were meaningful and spent time with people understanding how they could be achieved. People's care plans did not always include specific, person centred goals. For example, one person's stated goal in every area of need was 'to be more independent' but gave no detail on how the person should be supported to achieve this. This meant staff were unaware of how to help people improve their own outcomes.
- People and, where appropriate, their relatives were not always encouraged to contribute towards care planning. Care records did not always demonstrate people and their relatives had been involved in the planning of care. One person told us they had not been involved in developing their care plan. Another person's relative told us, "I haven't seen any care plans and I've not been asked to take part in reviews."
- The provider had not always ensured people were able to follow their interests and take part in activities important to them. For example, one person told us they were not able to go shopping as often as they would like as there was not always enough staff to facilitate the activity.

The provider had failed to assess people's needs and choices. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The registered manager told us they understood their responsibilities under the Accessible Information Standard. Despite having this knowledge, we found evidence of the Accessible Information Standard was

not always effectively implemented to ensure service users received information in a way they understood it.
● For example, one person's assessment indicated they had difficulties communicating and used an electronic device to aid communication. There were no instructions for staff to follow explaining how to make use of the device and the scenarios it would be best used in.

Improving care quality in response to complaints or concerns
● Some people told us the provider had not responded to them when raising complaints.
● The service failed to treat all concerns and complaints seriously, investigate them or learn lessons from the results. This meant the provider missed opportunities to improve the care people received.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance processes were ineffective and failed hold staff to account, keep people safe, protect people's rights and provide good quality care and support. The provider had failed to implement effective systems to assess, monitor and improve the service. The provider had not identified the concerns we found at this inspection, including the lack of robust risk assessments and care planning processes, poor safeguarding practices and ineffective risk management. This meant people were at risk of harm.
- The provider had implemented an action plan to drive improvements within the service in response to the concerns raised with them by the local authority. We looked at the plan and found where actions had been identified, they were not always addressed in good time. Furthermore, we found examples of actions being incorrectly marked as completed. This meant the provider was not addressing known concerns within the service putting people at risk of harm.
- Staff did not have regular supervision, to receive feedback on their performance and constructive feedback on how this might be improved. This meant the provider was unaware of staff's skills and areas of development. Furthermore, people were at risk of being supported by unsuitable or unskilled staff.
- The provider had not established robust systems and processes to enable staff to record and report accidents or incidents, and to ensure these were thoroughly investigated to minimise the risk of reoccurrence and drive improvement in the service. This meant people were at risk of avoidable harm.
- Records relating to people's care were not always accurate, up-to-date or complete. People's health appointments and visits were not always recorded. For example, one person had a decision made on their behalf as a result of an assessment carried out by an occupational therapist. We saw no record of this visit in the person's care file. This meant that there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.
- The provider had not actively sought the views of people, relatives, staff or visiting professionals on the service and how this might be improved. There were no recent records of feedback surveys or questionnaires being sent.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics; Working in partnership with others

● The provider's statement of purpose stated the aims of the service were to, 'Enable people who use services to live an independent and dignified life at home for as long as they are able or wish to do so by providing supports and services that are tailored to their unique needs, abilities, goals, aspirations and preferences. Services are flexible and responsive to changing needs.' We found little evidence the provider was meeting their own aims for the service. A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

● We saw no evidence that staff meetings or meetings with people and their relatives were taking place. This meant people and their relatives were not involved in the service, provided with key updates or given an open forum to raise suggestions or concerns.

● Not all staff understood whistleblowing or were aware of the provider's related policy. Whistleblowing is the term used when staff report certain types of wrongdoing within an organisation. This meant staff were not aware of how or where to report the provider's failings. The put people at risk of receiving poor care without improvements being made.

● The lack of effective quality assurance systems and processes, audits and regular staff meetings meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.

● Staff told us the registered manager and service manager were approachable and supportive and felt able to raise any concerns about people's care with them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We were not assured the provider or registered manager understood their responsibilities under the duty of candour, or their responsibility to be open and honest with people when care had not gone according to plan. For example, the local authority and CQC had not been informed when allegations of abuse had been made involving people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to assess people's needs and choices. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure service users were always treated with respect and dignity whilst receiving care and treatment This was a breach of Regulation 10 (Dignity and Respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care

	and treatment We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)

	Regulations 2014.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal Care